Health and Community Services Department Advisory Board
Part A – Meeting in Public
Minutes

Health and Community Services

Date: 29 February 2024	Time: 9:30 – 12:00pm	Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL

Board Members:		
Carolyn Downs CB - **CHAIR**	Non-Executive Director	**CD**
Anthony Hunter OBE	Non-Executive Director	**AH**
Dr Clare Gerada DBE	Non-Executive Director (TEAMS)	**CG**
Julie Garbutt	Non-Executive Director	**JG**
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong MBE	Medical Director	**PA**
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Bill Nutall	Director of Workforce	**BN**
In Attendance:		
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Obi Hasan	Finance Lead – HCS Change Team	**OH**
Beverley Edgar	Workforce Lead – HCS Change Team	**BE**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Jason Whitfield	Chief Information Officer (Item 6 only)	**JW**

1	**Welcome and Apologies**	**Action**

CD welcomed all in attendance and advised she would be chairing this morning's meeting. Tom Hayhoe (TH) was introduced and welcomed as the newly appointed Chair of the HCS Advisory Board (as of 28th Feb 2024). TH will chair next months meeting.

Both Deputy Andy Howell (Assistant Minister for Health and Social Services) and Deputy Karen Wilson were welcomed to the meeting.

Apologies received from:

Professor Simon Mackenzie	Medical Lead – HCS Change Team	**SMK**
Beverley Edgar	Workforce Lead – HCS Change Team *(leaving at 12pm)*	**BE**

2	**Declarations of Interest**	**Action**

No declarations.

3	**Minutes of the Previous Meeting**	**Action**

The minutes of the meeting on 25th January 2024 were agreed pending two minor changes from CG,

- CB in agreement that the issue of a public prescription for a private patient would be viewed as fraud in the NHS.
- The issue of conflicts of interest arose specifically regarding cannabis cultivation.

4	**Matters Arising and Action Tracker**	**Action**

ACTION 118: Following the appointment of TH, TH and CG to meet and discuss the frequency of rheumatology reports received at the Board. Rheumatology was discussed at the Quality, Safety

and Improvement Assurance Committee yesterday and a verbal update will be provided at item 10 on this morning's agenda. **ACTION 108**: The terms of reference are now available as of this week. ACTION: EOC to add as an addendum to the papers.	

5	Chair's Introductions	Action
As above.		

6	Chief Officer's Report	Action
JW in attendance to appraise the Board of the IT failure that occurred on Friday 23rd February (into Saturday 24th Feb), specifically what went wrong (from a technical perspective) and how HCS responded regarding business continuity. In summary, - A detailed report will be submitted once the investigation has concluded. Todays' appraisal is based on preliminary findings and facts thus far. - On Thursday 22nd Feb, a regular update to service systems was applied across GOJ from a third-party software provider. Approximately 200-300 of these are processed each year without the level of criticality experienced on the 23rd Feb. - From 8am, HCS users began to log-on in volume and were unable to do so. The effects were of a system switch off / power failure (noting that a power failure did not occur). - A Priority One incident was raised (red alert status for recovery). Systems were switched to various back up data centres however, this did not resolve the problem. - Close communications were maintained with CT to evaluate all options including moving to business continuity plans. - The business continuity plans were tested and were successful. - The use of the software involved has been suspended for 2 weeks whilst working closely with the software provider who provided the update to find the root cause. GOJ are not the first customer to receive this update and there have been no reports of this issue with any other customers of the third-party provider. This indicates there may be a technical issue with GOJ and anticipate that it will take the engineers 1-2 weeks to diagnose this fully. - JW apologised for the incident noting it was a very difficult day for the hospital and thanked CT and the wider team for the success of the business continuity plans. - CT advised that the IT issues were reported into the HCS operational centre. In addition, bed pressures also escalated at the same time. - Modernisation and Digital colleagues were positioned in the Operational centre which facilitated close communication. - On the recommendation of the medical / clinical lead in Theatres, elective activity was stopped in Theatres just after midday. - At all times, maintained the ability to care for patients safely in the Emergency department and Maternity with emergency theatres available if needed. - HCS staff's usual working environment was affected through implementation of business continuity plans. The loss of EPMA (Electronic Patient Medicine Administration) was the main effect in terms of inpatient care. - Whilst some areas were not impacted initially, all inpatient wards were moved to business continuity (BC) to minimise risk to patients. BC plans were maintained for EPMA until Sat 24th Feb 2024. - EPMA use was restarted at 2pm on Sat 24th once confidence of resolution had been received. In addition, bed pressures had eased. - A debrief will take place next week. However, no patient safety concerns or reports of harm have been raised. It is recognised that this was a very challenging day for staff. Approximately 34 patients were affected, predominantly outpatient appointments that had to be cancelled at very short notice (seven in day surgery unit and three in main theatres). All cancelled activity has been rescheduled. Apologies given to all patients that were affected by this.		

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CB took the report as read and verbally summarised the key points. In addition,

- Cultural change: Racism will not be tolerated within HCS. Stories from staff from ethnic minorities are saddening. An antiracism statement will be presented to the board in March 2024.
- Financial recovery programme: Savings of at least £12million will need to be found this year.
- Staff achievements: Donna Murphy was announced as the winner of National MyPorter Awards: International Porter of the Year Award. This is a great achievement that was recognised by the HCS Executive Leadership team earlier this week.

CD thanked CB for his report. CD extended the Boards congratulations to Donna Murphy and suggested she would be a good candidate for an employee of the year award.

Noting that many of the issues highlighted in the report are covered through separate agenda items, CD invited questions regarding additional matters.

AH thanked CB for his report which provides a comprehensive overview of issues affecting HCS. Whilst HCS is facing a large programme of improvement work, green shoots are visible.

As there is no finance report available, CD asked OH for his initial view on the financial position following Month 1. OH explained that HCS exited 2023 with more cost pressures than forecast and there are specific reasons for this. These cost pressures will be carried into 2024. A large number of actions and improvements have been implemented through the financial recovery programme which will make a positive impact. However, there are dependencies on delivering the improvements and timing is key. Critical actions remain regarding recruitment and reducing spend on agency / locum.

CD asked AW to touch on the main learning points from the inquest during item 13.

CG asked what the main delays in onboarding staff are? CD asked for this to be covered in the broader workforce report at item 9.

7	Quality and Performance Report (QPR) Month 1	Action

Noting that the report is received monthly, CD asked CT (and other executives) to highlight any trends that raise concerns.

- The impact of the waiting list recovery can be seen through those waiting > 52 weeks.
- Legacy issues (following Covid) remain in some specialities, but these are all being addressed by waiting list recovery plans.
- The DMO1 diagnostic standard is a new standard.
- New to follow up is improving.
- The 4-hour standard for emergency care has been introduced. This is not only a measure of patient experience but also a measure of internal efficiencies and performance of the whole health system. Patients continue to wait in the ED > 12 hours but some of these patients will have returned home. Those waiting for admission will have been delayed due to access to side rooms.

Noting that one of the explanations for cancelling surgery is *where patients have not been adequately communicated with,* CD asked for further detail regarding this. CT responded for operations cancelled on the day, rather than bed availability, this was mainly due to administration issues including patients being informed adequately ahead of their surgery and accessing pre-operative assessment services. Ensuring patients receive their letter and developing a 'choose and book' system are focus actions. In addition, a text remainder service exists for outpatients but not inpatients. CD noted that all these actions are entirely within the control of HCS and therefore resolving these is imperative. CT explained that these metrics are

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monitored through a weekly task and finish and anticipates being able to demonstrate improvements next month.

ACTION: CT to include the impact of weekly task and finish upon cancellations (and reasons for cancellation).

AH advised that the Board should be focussing on a broader suite of indicators which are about a healthy, sustainable quality of life which reduces need for hospital admissions and encourages safe discharge. AH and AW have been discussing what these metrics could be and invited AW to comment further. CD also asked AW to update on why the position for delayed transfers of care has deteriorated from last year.

AW advised that the QPR is an integrated performance report with both mental health services and adult social care metrics and agreed with AH that the conversations and discussions must reflect the whole system rather than the hospital only.

Noting that the crisis team were able to see 94% of individuals within 4 hours this month, this is the best achievement to-date. In addition, the service also continues to achieve the KPI for follow up on discharge from hospital within 3 days which is a key harm reduction target.

Areas for escalation include waiting times for Memory Assessment Service (MAS) and ADHD. However, a productive meeting was held with the MAS last week where an improvement trajectory was developed, involving a partial redesign of the diagnostic pathway to expedite the patient journey. With staff working in different ways and additional medical diagnostic capacity, hoping to see positive change in the delays regarding MAS.

The adult social care service has been working to develop other indicators. However, as previously noted, the KPIs in the QPR are supported by a range of other indicators which are reviewed as part of the monthly governance processes. TH and AW will continue to work towards other KPIs for inclusion within the QPR, however, whilst process measures are important, outcome measures will indicate the work and delivery of social care services and also any gaps.

Regarding delayed transfers of care (DTOC), one of the key issues from Jan-June 2023 was access to packages of care. At any given time, approx. 50% of people of waiting were delayed due to availability of packages of care. The new brokerage system managed through Customer and Local Services (CLS) has been very effective and the number of patients waiting for packages of care has reduced significantly.

Lack of availability of nursing care is now a significant reason for current delays and includes the availability of nursing care in Jersey for complex needs of individuals, particularly dementia. In addition, during January 2024 there has been some reduction due to temporary closing of nursing care beds (refurbishment etc). However, there is a weekly integrated meeting (hospital, social care and community services) chaired by either CT or AW to ensure that issues in the community are addressed as quickly as possible.

Housing is also an issue and at any given time there are approx. 3-4 people waiting for housing. As an example, an individual has been waiting in the hospital for a home with adaptations since beginning of November 2023. Multiple senior level conversations with the housing department have been unable to resolve this. Noting that an individual's health and independence is likely to deteriorate whilst waiting in hospital, CD noted this wait is unacceptable. CD noted that this is an escalation issue for CB and politicians to discuss.

As a final comment, AH noted Jersey's opportunity to develop an integrated GOJ led person-centred approach to good quality care, support and early intervention.

In response to CG's questions about remote physiotherapy, CT and CG will discuss further outside this meeting.

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ACTION: CG and CT to discuss remote physiotherapy opportunities.

8	Waiting List Report Month 1	Action

Taking the paper as read, CD invited CT to highlight any issues that require the Board's attention.

- The waiting list for both inpatient and outpatient is reducing in volume.
- There are well developed plans to reduce those waiting > 52 weeks, particularly in Ophthalmology (outsourcing cataract surgery).
- Waiting list recovery schemes are expected to address those waiting > 52 weeks on inpatient list over the next couple of months.
- Following this, work will focus on those waiting > 90 days.
- There are surveillance patients included in both inpatient and outpatient waiting lists and a separate list needs to be developed for this group of patients. In addition, Jersey does not have the ability to suspend patients (those who are not fit for surgery or those who are choosing not to attend). Both issues distort the overall list and prevent accurate benchmarking.
- Improvements continue to be demonstrated in endoscopy and MRI scanning.
- The risks around dermatology are driven by the inability to recruit to long-standing vacancies. Some progress has been made but a longer-term strategy is required.

ACTION: The impact of the implementation of the new electronic patient record (EPR) upon the waiting list to be included in the March report.

Using general medicine as an example, CD asked why there are larger numbers of people waiting > 52 weeks than at 0-30 days etc. CT responded that this group of patients is monitored weekly and often these patients state they are not available for their scheduled appointment. According to the access policy, patients that have declined to attend multiple appointments require a discussion with the responsible clinician to see if they need to remain on the waiting list. CD suggested that HCS should consider when these patients rejoin the waiting list (rather than stay on the end). CB referenced the previous discussion regarding suspension (item 7) and suggested a separate list for this group of patients as this is distorting the waiting list data.

Regarding reference to *Clinical Genetics (103) accurate and addressed through budget setting 2024 and new service approach and move to PPI CG*, CD asked what this means. CT explained that HCS has a contract with a UK provider for this service and the majority of people referred have been seen. Historically, HCS has not had a budget for this, however, additional funds have been identified through budget setting to continue the service in a different way. The service is screening for particular cancers where there is a family history.

Regarding the EPR, CT explained that the previous system Trakcare was an episode-based system. MAXIMS (current system) is a referral base system which allows HCS to assess performance of referral to treatment (conclusion of whole treatment plans). However, the waiting list was artificially inflated as MAXIMS was introduced. Whilst the numbers described are those on the waiting list, further validation and training and support is required.

CD asked when the cleansed data will be available and in addition, when will benchmarking be included.

ACTION: CT will present the fully validated waiting lists within the next three months.

The waiting lists are expected to be published again on the GOJ website at the end of March 2024.

9	Workforce Report Month 1	Action

Paper taken as read and CD invited BN to highlight any key issues.

- Vacancies require work and possible solutions will be discussed shortly.

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- The total turnover rate has remained constant in the last year at around 7% - The sickness rate has increased through January 2024. Support is provided from AXA healthcare and BN in discussion with People and Corporate Services to understand how this support can be strengthened. - A key challenge is performance management through Connected Performance. However, this is predicated at this time of year. Granular information will be reviewed consistently and continually by the executive and senior leadership team on HCS (ELT / SLT). Possible solutions, - Three recruiters have been seconded to HR to try and improve recruitment performance. Changes in style of recruitment and engagement must change. A recruitment mapping exercise has been carried out as part of the financial recovery programme and 66 micro steps have been identified in the recruitment pipeline. A workshop is planned for 7th March to reduce this to twelve steps. - Aiming to have the correct infrastructure to support an effective recruitment process in place by end March 2024. Anticipating the impacts of this will start to be seen 2-3 months after this. - Aiming to reduce the pipeline from approx. 100 days to 55-60 days. - The 'Refer a Friend' scheme will be going live in 2 weeks. In summary, the systems need to be fully aligned, the infrastructure must be established with operational managers and there are a variety of other projects planned. Referencing CG's earlier question regarding delays in the onboarding process, CG indicated she is happy that this has been answered. ACTION: CD asked for the recruitment mapping process showing the 66 micro-steps to be presented at the People and Culture Committee planned for the end of March 2024. BE commented that there are 500 vacancies across HCS and only 108 live vacancies, meaning that HCS is not recruiting to the 500. There are factors within HCS control that need to be improved including preparing the job advert much more quickly. In additions, specific campaigns for healthcare assistants (HCAs), mental health services, therapies and nursing are required to run alongside the improvement initiatives. ACTION: HCA recruitment campaigns to be placed on the agenda for the People and Culture Committee. Following a visit by CD and AH to some of the wards yesterday, various nurses commented that staffing issues experienced relate to HCAs. BN advised following discussions with the acting Chief People Officer, the support of a nurse specialist recruiter has been secured to provide a consultancy-based service to further develop and launch the nursing micro-site and explore niche recruitment areas. In response to BE's comment about job advert, AW suggested that the process of getting an advert out needs to be included in the process mapping as this is one of the longest processes. AW advised that the number of HCS applicants has reduced in response to market growth and in response to this, apprenticeships are being explored. Following a discussion regarding appraisals, it was agreed that the data reflects the number that have been placed on the system, rather than those that have actually been done. ACTION: Appraisal rates to be included in the People and Culture Committee.	

10	**Quality, Safety and Improvement Committee**	**Action**
Due to some technical issues, PA provided a verbal summary of the key outcomes of the committee meeting (rather than CG as Chair).		

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1. Terms of Reference: The name of the committee has been changed to Quality, Safety and Improvement to better reflect the function and purpose of the committee. The terms of reference have been reviewed and amended, including the membership. The terms of reference will be presented at the next Board meeting for approval.

2. Quality Indicators: Noted with no immediate concerns.

3. NICE Guidance compliance: Received assurance that HCS has communicated the policy change however, there is limited assurance that NICE / other evidence-based practice is being followed. Once recruited, this will be a priority for the Head of Compliance and Regulation as HCS prepares for inspection and is an important piece of work for the Medical Director and Chief Nurse to focus on. The committee will continue to monitor, noting that this will be a 2-year plan. Escalations and exemptions will be reported to Board through this committee.

4. Prescribing data: Asked for amended metrics. Reviewed Medicine Optimisation terms of reference and suggested amendments – this will be a subcommittee of this committee. Concerns regarding hospital versus community prescriptions. Cannabis - capacity issues that need resourcing as soon as possible.

5. Serious Incidents: One never event noted, and any immediate safety concerns have been addressed. This will be presented to Board in more detail following investigation.

6. Rheumatology: This committee will receive progress against recommendations and continue to monitor changes in practice for assurance that these have embedded.

7. AOB: Sodium valproate (a drug used to treat epilepsy) carries significant risk to women of childbearing age and also men. Progress against actions in the safety alert will be provided to the committee.

Referring to the long queues outside pharmacy, CD stated this is an area that needs to be resolved. CG advised this is not a simple issue due to the funding streams and is a political issue for resolution. PA advised that approx. 50% of HCS outpatient prescriptions are medications that are on the prescribers list. However, as hospital doctors are not on the prescribers list, they cannot prescribe these medications to be dispensed from a community pharmacist. This relates to the funding as medicines dispensed in community pharmacies are paid for from the Health Insurance Fund (HIF).

PA confirmed the committee will be meeting quarterly. A written report will be provided for the meeting in March.

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11	Medical Job Planning	Action
CD explained that the Board raised concerns at the last meeting as a pause in the process was suggested. This report provides a plan to get the process back on track and completed by end October 2024. The Board noted this and thanked PA / SMK for managing this. No further discussions required.		

12	Medicine Improvement Plan	Action
Paper taken as read and some key points highlighted, - The Medicine Improvement Group meets every two weeks with executive and change programme colleagues monitoring progress. The group last met yesterday (28th Feb). - Further progress has been made closing some of the actions and recommendations. Evidence of this can be found in the appendix. - Key activities in the last month include advertising the five additional General Medicine Consultant posts and there has been good interest. In addition, capacity has been secured for a flow coordinator to support discharge and patient flow.		

- Focus will now move to amber actions within the 0–6-month period. There is now good evidence to demonstrate that there is routine approach to patient documentation.

Noting that the interest in the five Consultant posts is excellent, CB stated that it is important that HCS does not lose these potential candidates because of lack of engagement / onboarding.

JG asked what approach will be taken to the six unfunded Consultant posts. CB explained there is no funding for these and not expecting that additional funding can be secured from GOJ. OH confirmed that a business case will need to be submitted. CB advised that the only way to fund this would be to reduce service(s) elsewhere and there will be difficult decisions for the ELT and the Advisory Board as to what can and cannot be funded. JG stated it is important to understand these and the impact on patients.

CD concluded that it is good to see work progressing.

13	Mental Health External Review Implementation	Action

AW explained this is a 2-year update on the implementation of the external review of Mental Health Servies that was commissioned in 2021. Ten sets of recommendations were made regarding the safety, quality management and development of Mental Health Services. A clear plan was established following AWs arrival at the beginning of 2022 to address the recommendations.

A large part of the work required was cultural change which takes longer and needs to be sustained.

The focus of the first year was the redesign of Community Mental Health Services (CMHS) due to concerns regarding access, frequency of follow-up and outcomes. The priorities were agreed with service-users and carers. The CMHS services review was a whole scale change involving > 120 staff. However, a clear structure for CMHS emerged.

The paper describes in detail the action taken against the recommendations with evidence incorporated. Whilst the majority of the actions have been implemented, there are some areas with further work to do.

- The introduction of the Care Recovery Framework (CARF) which is long overdue. This is the framework by which HCS will deliver secondary MH care to individuals with serious mental illness. The framework is being audited from a process perspective and quality perspective. The leadership from MHS met with each of the care coordinators not only to discuss the frequency of meetings with people, the availability of risk assessments and care plans, involvement of the service user but what are the interventions and what is the quality of the work. This work is being drawn together to evaluate what additional work is required.
- A MH Partnership Board has been established which includes third sector partners, Police, Prison services and other areas of GOJ. This has commissioned pieces of work including co-production policy and for the first time, system KPI's have been developed which is step forward.
- Legislation is progressing. A multi-agency assurance group meets monthly to review all use of MH law and use restrictive practices. This allows quick identification and resolution of issues.
- Inpatient services are a focus for this year – quality improvement and the move from Orchard House to Clinique Pinel. The physical environment will be much improved and provides an opportunity to introduce an Article 36 suite.

Noting that regular reporting has taken place over the last 2 years, AW proposed that this ceases and the work is monitored through business-as-usual governance processes.

Whilst recognising the longevity of the cultural change, AW congratulated the senior leadership team within MHS for the large amount of work achieved in the last two years. CD and the wider Board in agreement and supported the proposal regarding business-as-usual reporting.

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CD asked for an up-date regarding learning from the inquest. AW explained that following Mr Watkins death an external review was carried out which made a series of recommendations which have been implemented. The findings of the inquest were similar to that of the external review, particularly joint working between MHS and the general hospital – when someone has complex physical health needs and mental health needs at the same time, how do services work together to ensure the needs are met in entirety. A piece of work has started jointly between MHS and the hospital.

The finding of neglect specifically related to the failure to identify that Mr Watkins was dying and escalate care back to the general hospital. Other issues related to clinical documentation (decisions, rationale) and nursing staff behaviour. AW has written to all staff within MHS setting out the issues and findings from both the inquest and the external review. The coroner identified that work that has been carried out by MHS over the last 2-years and was satisfied to the extent that a Prevention of Deaths finding was not issued. However, this is terrible incident and the family have been met and apologised to.

CD emphasised that HCS must learn from this and the link between MHS and acute services is an issue within other healthcare jurisdictions. CD noted that excellent nursing care was witnessed yesterday for an older adult with dementia, however, this distracts from delivering acute care. CD stated it would be very beneficial to see how this work progresses as it is an important matter and one of concern, not only in Jersey but across the world. AW responded that a working group has been established including AW and JM with representatives from both MHS and the general hospital to specifically review the care of people with dementia and delirium within the general hospital and how this is done together. This was echoed by AH and the integrated approach to measuring performance is very important.

ACTION: CD asked for an update of this work as it progress (timescale to be determined).

CB noted the reference to poor documentation, and this was a theme that also emerged through the rheumatology review – this area continues to require improvement.

14	Maternity Improvement Plan	Action

Paper taken as read and PA invited to highlight any changes from last month.

- The service is very keen to include the voice of women and their families and future reports will include feedback from the Jersey Maternity Voices Partnership.
- The previous ‘red’ recommendation regarding culture is now ‘amber’ (due to the progression of the cultural change programme). However, further work is required.
- The project management support is undertaking 30-, 60- and 90-day reviews to ensure that each recommendation is embedded within business-as-usual activities. There are 66 recommendations over 90 days and there is good evidence to show that 60 of these have embedded change following review. The remaining six are not of concern currently.
- Recruitment to Consultant vacancies has been unsuccessful so far and going out to advert again shortly. The interim Chief of Service is doing great work, but this post needs to be substantiated.

CB invited PA, CS and JM to comment on whether the guidelines for the management of post-partum haemorrhage (PPH) and massive obstetric haemorrhage (MOH) are being followed. PA advised that the numbers have reduced since last year, however, it will never reach zero as these events will occur. Any incident of MOH is considered by the Serious Incident Review Panel (SIRP) and the management of these has improved. The number of MOHs declared as serious incidents (SIs) has also reduced.

15	HCS Annual Plan 2024	Action

CD noted that the Annual Plan 2024 can be considered as agreed (now in Feb 2024) and suggested work towards the Annual Plan for 2025 could occur earlier with ministerial input.

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AM advised that the Annual Plan 2024 provides a joint overview of a number of improvement areas whilst also explaining accountability structures from the operational departments through to the Minister for Health and Social Services.

There are two items that have delayed this document being presented to the Board,

1. Ministerial priorities: awaiting current ministerial priorities following change in January 2024.
2. Board Assurance Framework: anticipating presentation to the Board in March 2024.

CD thanked AM noting it as a clear document, particularly the action plans which details accountabilities and timescales.

JG echoed CD's comments and further reflected that the diagram on page 10 demonstrates the complexity of health and social care. Increased integration is a driver within most healthcare systems and this diagram shows how fragmented the system is in Jersey. Service-users do not recognise individual organisations and boundaries, they just have needs that must be met – where there are multiple boundaries patients can fall through gaps. Using the example of the Mental Health Services Partnership (whole system view), this is way of managing these gaps and reducing overlaps and omissions.

However, as the health system spends approx. £50 million commissioning services (both on and off-Island), this would be a helpful addition to the document. CB reminded the Board / public that HCS is not just a provision organisation and it also commissions services. In other healthcare jurisdictions, separate organisations manage the commissioning function.

A ministerial priority was agreed regarding the establishment of an Island Health and Care Strategy during 2024 and this is an urgent requirement. This strategy must include how the disconnect across all services (public, private and third sector) is managed and supports integration.

CD stated her main concern is the financial recovery programme referred to in the Annual Plan and whilst OH is confident that the plan will be delivered overall, at what point in the year will this occur and will the financial position affect delivery.

ACTION: AM will update the Annual Plan 2024 to include commissioning and the ministerial priorities once determined.

CD suggested some minor rewording regarding workforce.

14	**#BeOurBest Programme – Annual Update**	**Action**

AM noted that the Board received a detailed report during 2023. Paper taken as read which provides an annual review and summary of the achievements made so far.

Key objectives requested by the review and actions set out by the Minister in her Report have been addressed and implemented. These include the establishment of the HCS Advisory Board, provision of additional resources and expertise (Change Team), adoption and implementation of NICE guidelines, appointment of a Freedom to Speak Up Guardian, establishment of a Private Patient strategy, development of accountability frameworks and assurance reporting mechanisms, independent feedback on patient experience, clarity of roles and responsibilities, establishment of a health policy function, patient focus, cultural change programme and workforce.

Noting that the programme governance established to oversee the action planning and monitoring of recommendations has been in place since 2022, AM recommended that the existing governance structures (Board and Assurance Committees) are now used to set the objectives and monitor progress with recommendations and actions.

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Acknowledging the large amount of improvement activity that has and continues to take place. How can HCS be assured that this is making a difference, particularly regarding culture? CB responded that there a variety of methods that can be used including BeHeard Survey and Pulse Surveys. CP advised that a key measure is engagement with HCS and there has been a positive increase seen through Team Talks. In addition there a number of engagement indicators including award and recognition events. Engagement is increasing from staff groups who have typically been hard to reach (lower grade staff and those where English is not their first language) – now thinking creatively about how forums can be built for these groups to enable their voice to be heard and provide feedback. In addition, medical staff have not engaged as well as other professional groups and working to enable their voice to be heard.

CD suggested the development of a dashboard to demonstrate how the organisation feels different. CP responded that the dashboard has been in development with the Head of Health Informatics over the last two months, understanding what the KPIs would be for staff and patients (as the aim is to deliver high quality safe care to patients).

BN noted that activity through the Freedom To Speak Up Guardian (FTSUG) is a good indicator, and the increased activity demonstrates that individuals are feeling more confident to speak up. CB advised that individuals also approach himself and other Directors more willingly to discuss matters of concern.

ACTION: CP to present the dashboard at a future Board meeting (timescale to be agreed)

	Questions from the Public	Action

Person A: Can the Board think about a speak up guardian for patients and publicise this really well?

Response: JM responded that the Head of Patient Experience role is currently vacant, but a member of the team is acting up into this role to oversee the service (PALS and feedback). The signposting to the service has been raised through the Patient Panel at the beginning of Feb 2024. A comms plan is in progress as it is acknowledged that the PALS and feedback service has not been launched well, including access arrangements. The first point of contact should be through the PALS service and the team is located at the front of the Hospital – however, this is not well sign posted for people to access and working to resolve this. The PALS team should be able to resolve any issues within five days and if not, it moves into a formal complaint. However, the emphasis is early resolution. JM has reached out to UK colleagues who confirmed that their PALS office is the first point of contact. A senior nurse for patient experience sits in the team and for more complex issues, this nurse can be called into PALS to support whoever is raising an issue. In summary, HCS is really trying to improve the service with the patient experience team and to make it more accessible to all the public.

ACTION: CD asked for this issue to be brought back to the next Board meeting.

CG advised that it was proposed at the Quality, Safety and Improvement Committee yesterday to have a lay member (recruitment to be determined) and also start each meeting with the patient voice.

Person A suggested that following the well-publicised FTSUG, there should be an equally well publicised equivalent for patients.

CS advised that the office of the Chief Nurse is also assessing how Martha's Rule can be introduced which once fully implemented provides patients, families and carers 24-hour access to a review and being heard. This will also need to be well-publicised.

TH responded that this relates to the previous discussion regarding the impact of the improvement work and how the organisation feels different.

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Person B: Commented that the Board is a good thing providing openness and transparency for the people of Jersey. Using a personal example, B highlights the topic of recruitment and retention. It took 10 months for the Sates Employment Board (SEB) to approve funding for his replacement after his retirement was announced. This must be addressed. In addition, when recruiting, candidates are waiting at least 9-10 months for the offer to come through. There has been a campaign to recruit HCAs and there were only seven applicants / successful recruits following this – things need to be done differently. Exit interviews are important to understand why people leave the organisation. Referencing CG's question about remote physiotherapy and long waiting times, B stated that six physiotherapists resigned approx. one year ago, and the organisation does not know why (through formal channels). Many locums enjoy working in Jersey and are renumerated substantially higher than the standard contract. Consequently, when these individuals apply for substantive positions, they want similar renumeration which cannot be done. The pay structure for Consultants needs to be reviewed to retain the current workforce and attract people from elsewhere. CD thanked B for points well made. **Person C:** Using a personal example, C highlighted that the correct information was not given to her in a timely manner and if she had not acted, her planned surgery would have been cancelled. CD noted this is not good enough but is a good example of what was discussed earlier in the agenda (item 7). **Person D**: Identified herself as an ex-Civil Servant who did not have an exit interview and is aware of staff who have left recently without an exit interview. Response: CD thanked D for this and as the exit interviews are not managed by HCS, CD asked BN to escalate this appropriately and explore whether HCS can conduct these. TH thanked CD for chairing the meeting to a very high standard. Noting the discussions about patient experience and hearing the patient voice, TH advised he is passionately committed to hearing the patient voice and other roles reflect this passion. CD thanked all in attendance for their contribution and participation and EOC / DL for the preparatory work.	

	MEETING CLOSE	Action
Date of next meeting: Thursday 28th March 2024		

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